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Substance Use Disorder (SUD) Inpatient and Residential Treatment Waiver Development
Stakeholder Engagement Meetings Summary
June 2019

Three meetings were held on June 19 (Colorado Springs), June 20 (Greeley), and June 20 (virtual meeting). Approximately 15 people attended each in-person meeting and approximately 40 attendees joined the virtual meeting.

Meeting slides are available on the Department of Health Care Policy and Financing (HCPF) Ensuring a Full Continuum of SUD Benefits website.

Discussion topics and questions from the meetings are summarized below.

Meeting Goals

- Provide background on the waiver and work to date.
- Review and discuss content of the wavier application.
- Identify next steps in the waiver submission process.

Bulleted discussion items were raised by meeting attendees. HCPF responses are identified as such.

Discussion Topic: ED utilization and care coordination

In response to the information that an expected reduction in ED visits will be included in budget neutrality calculations, the following questions and issues were raised:

- Will the RAEs manage hospitalizations and emergency room visits?

  HCPF: Emergency room visits will not fall under the capitation; they will remain under the physical health benefit.

- Outpatient providers do not receive information about emergency room visits for patients receiving SUD services; this makes it difficult to conduct care coordination if our patients visit an emergency room.
- For example, people who are high need and are on MAT and end up in the emergency room, their provider may never know about that emergency room visits.
- Some programs have the person sign a form for the program to release information with the treatment program after hospitalization, but it is not always the case that people will sign.
- The hospital does provide some data for mental health services, but substance use is different. How do we provide continuity of care between hospitals and treatment programs?
- This has been a highly debated topic. A Key Performance Indicator (KPI) was established based on follow-up services for people in the emergency room who were there for substance use

problems. They could not get data because of confidentiality so they had to go back and change the program KPIs.

- People may be overly conscious of 42 CFR Part 2 – we are starting to see a
- trickle of information coming out, but not enough to do great care coordination.

HCPF: Based on what has been said about this issue today, it appears to be an issue that predates the waiver. The Department will examine the issue as it relates to the waiver and care coordination requirements for the implementation plan.

Discussion Topic: Care coordination

- Will there be a step-down process for high to lower levels of care?

HCPF: We hope providers and RAEs will establish processes, but we will provide some direction. We must show quantitative improvements to CMS on care coordination – this requirement is reflected in the implementation plan milestones.

- If a provider wants MAT to continue or be reduced in residential, would there need to be medical monitoring in residential services?

HCPF: The level of medical monitoring would need to be available consistent with ASAM criteria.

Discussion Topic: Contracts and Processes Timing

- What is the timing of the contract process, specifically with the RAEs?
- There are concerns about what contracts and codes need to be updated in the system.
- At a bare minimum, RAEs would need 90 days to provide a notice to providers and allow for negotiations.

HCPF: The Department appreciates the need for time to develop contracts between the RAE's and providers. Contract amendments are included on the current project workplan and will be initiated as soon as the waiver benefits have been agreed upon with CMS.

- Does CMS recognize a need to fast track the waiver approval to respond to the national crisis?

HCPF: CMS has opened up the 1115 as a pathway for states to cover services in IMD's because of its recognition of the need for these services. CMS is working with states collaboratively in their review of these waivers. This waiver opportunity was created in part as a response to the opioid crisis. There is also evidence that CMS recognizes that states will not have adequate capacity for all services at the time waivered services are introduced. The implementation plan template allows for the development of a plan

that addresses capacity over a 12-24 month period after waivered services are introduced.

- Do we know what CPT or revenue codes will be opened?

  HCPF: We recently started work in that area. We have researched what other states are using for these services and have convened a work group that will identify coding procedures for the new services.

Discussion Topic: Licensing

- What do providers need to do to update licenses with the Office of Behavioral Health (OBH) for different sites and levels of care?
- If a provider changes levels of care provided or sites which provide the care, all those changes require new licensing requests.
- OBH standards need to be updated to clarify what the new requirements are.
- From a payer perspective, if a provider doesn't have a license, they cannot provide services. This process takes a long-time.
- The licensing process is not quick – it takes months to review policies, visits, etc.
- Are we emphasizing co-occurring treatment or just substance use disorder treatment?
- If there is a focus on co-occurring, this is a large cost service compared to just substance use treatment.

  HCPF: We understand the need for co-occurring services and are looking at how these fit into the benefits.

- Is this licensure transferring to Colorado Department of Public Health and Environment?

HCPF: Colorado Department of Public Health and Environment will take on SUD licensing in two years, but they have been involved in early discussions about modifications to licensure rules under OBG. The hope is that the rule changes will be complete prior to the opening of the benefit and when the licensing is handed off to CDPHE, the rules will be consistent with ASAM criteria descriptions of levels of care.

Discussion Topic: Network Adequacy

- As the waiver is implemented, how will provider capacity be tracked? Are there network adequacy requirements?
- It is hard to measure demand for services for patients who aren't receiving care, or they are receiving care through the block grant funding or other programs.

HCPF: None of this has been decided up to this point, but it is on our minds. OBH is rolling out Compass (which combines DACODs and CCAR data systems), which will put in ASAM requirements and track recommended level of care. This will track what a patient's needs are regardless of funding source.

Regarding network adequacy, requirements have yet to be determined —more specifically, we have not determined what network requirements we will have for the RAEs. The tension is between setting consistent rules across the board and allowing the RAE's to develop networks that suit their region's needs and workforce limitations.

- There should be a focus on assisting existing providers expand in their area, rather than new providers come in and build new facilities, for sustainability of staffing and providers.
- Are community corrections being considered in community capacity assessment?

HCPF: We have had several conversations with criminal justice entities about how the waiver will intersect with the criminal justice population and how length of stay will be managed given sometimes differing recommendations from CJ entities and medical necessity. CMS has been clear that those individuals residing in community corrections are Medicaid eligible, other than a few facilities that are in a correctional facility.

- What do you think about capacity to meet inpatient need?

HCPF: We anticipate that there will be a large demand for these services. Some work has showed that there is less capacity at the 3.7 level than is reflected by the currently licensed providers, but we know that fewer patients need that level of care. More patients will need treatment at the 3.1 and 3.5 levels of care. We believe that we will have a large group of people seeking services and need an additional capacity. CMS knows that there will be insufficient capacity for services when they are introduced in states. The implementation plan will reflect the plans for capacity expansion.

Discussion Topic: Provider Credentialing

- There are challenges with making sure that every substance use disorder treatment program has 50 percent of staff be credentialed as a certified addiction counselor (CAC).
- In Pueblo there are not enough people to hire, and workforce across the state will be a challenge.
- One thing to consider is telehealth as a possibility, could be used for medication-assisted treatment (MAT) services and support for extra hours for recovery counseling.

- However, with telehealth, there are some rural communities who do not have internet access which is problematic.
- Perhaps there is potential to utilize equipment at a Veterans Administration (VA) facility which has been providing telehealth in rural areas.
- Workforce is not just a rural problem, the Golden area VA does not have a psychiatrist, and the Pueblo VA has discontinued substance use treatment services.
- Reimbursement is critical for ensuring an adequate workforce. If an agency is not adequately reimbursed for services, recruiting staff is not possible.

Discussion Topic: Rates

- Is there any vision for what services will be paid for? For example, per person or per group?

  HCPF: Residential services will be paid for with a daily rate. CMS has a restriction for covering room and board, so treatment will be provided separately from room and board which will be paid through the block grants through OBH.
- Will per diem rates set by HCPF or RAES?

  HCPF: RAEs will negotiate rates with providers.

- Related to the announcement about the change in the manner in which billing occurs for 3.2 WM - Does this mean providers won't get paid per diem for detox services? There are concerns about reimbursement rates.

  HCPF: It wouldn't be billed for a certain number of times, but it would be single per diem rates. The idea is that this is desirable for providers.

Discussion Topic: Treatment Definitions and Goals

- Will this benefit allow for services to be provided out of Colorado?

HCPF: It is unclear at this moment, but we have talked about it for tribal populations because of their locations or having access to services that are more culturally responsive.

- Does an individual need to have a medical diagnosis to qualify for the waiver services?

  HCPF: They need to have a covered SUD diagnosis and medical necessity must be demonstrated as well.

- For people getting different levels of care, will they need ED clearance before they are transferred to these settings?

HCPF: No ED clearance is necessary, but prior authorization will be required.

- How do you define medically monitored?

  HCPF: As ASAM defines it. 24 hour nursing is one requirement that some facilities may lack. A lot of programs do not have full 3.7 level of care services because of cost. We also understand that staff retention is an issue that makes this staffing difficult.

- Are there restrictions based on substance of choice?

  HCPF: No, there will be not prioritization or restriction based on the specific substance that is used by the patient.

- Are there priority populations for waiver services?

  HCPF: We won't have priority populations for these services. Additionally, we will not pay for room and board, but OBH will use the block grant funds to cover room and board.

- Will this benefit open services for correctional facilities? Will Medicaid pay for this in jails? One of the things noted with MAT is that I see the "MA", but not a lot of the "T". I am hoping that there is greater oversite to have the full range of services provided. In jails we need to provide treatment services in the jails to facilitate successful MAT, but it is not an allowable service, and there is only so much state jail-based behavioral health services (JBBS) funds can provide.
- My concern is that as we move towards providing MAT, which is an expensive service, it is not billable. This means JBBS funds will be depleted and reduce from other treatment services that are needed. Arapahoe county is in the process of implementing induction in jails. As of now if they person needs therapy, we are eating the cost to provide that service in jails.

  HCPF: Medicaid is unable to cover services for individuals who are incarcerated.

- What impact does the benefit have on the Special Connections?

  HCPF: We are still answering this with CMS. What we know so far, with the waiver in place it will remove the IMD restriction for those providers as well.

- Will utilization management be the RAEs role?

  HCPF: Yes, the conversation will happen around ASAM requirements. We have yet to decide on if there will be a specific tool, but some states have required specific

assessment tools. Additionally, we are trying to understand the recent parity legislation and the role that legislation will play with this issue.

- Will there be contractual guidelines to the RAES for utilization management practices?

  HCPF: We will require prior authorization for stays. We have yet to make those decisions, but we will be balanced to ensure CMS guidelines are met and allow some RAE flexibility.
- Will there be guidance or requirements for evidence-based practices to determine level of care? One of the challenges with evidence-based practices is that some are costly, specifically the training or implementation process. It would be nice to have some support for providers, as it could be a barrier to opening doors or expanding them.

  HCPF: I don't know how prescriptive we will be, but the RAEs may have their own requirements. Part of that will be our work with the quality team – which is the monitoring and evaluation piece.

- How will you establish recovery-oriented services throughout the continuum and use recovery supports?

  HCPF: We are attentive to the fact that recovery helps maintain treatment success. Currently, support for recovery peer supports can be billed for, and we will ensure coverage for those services which exist at this point. We are also working with RAEs who will work with providers to ensure coordination of care.

- Do you intend to include ASAM guidelines that recommend HIV screening upon intake? This is a CDC best practice, and some states have done this.

  HCPF: This is not something we have made decisions on at this point, but we will take it into consideration.

- Any updates on how you plan to handle continuum of care for adolescents?

  HCPF: The waiver will apply to that population as well.

- Can you clarify again the number of days that will be covered?

  HCPF: There is not a specified number of days. Length of stay will be based on medical necessity.